MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

COPY

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes ( ) No
Requestor's Name and Address Americare Pain Management 3500 Oak Lawn, Suite 380 Dallas, TX 75219	MDR Tracking No.: M4-05-0189-01 TWCC No.: [redacted] Injured Employee's Name: [redacted] Date of Injury: [redacted]
Respondent's Name and Address Richardson Hospital Authority BOX #: 11	Employer's Name: [redacted] Insurance Carrier's No.: [redacted]

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
9/8/03	4/22/04	90801, 90855, 97799CP	$13,812.63	$9672.64

PART III: REQUESTOR'S POSITION SUMMARY

The requestor states in part "the services billed were preauthorized."

PART IV: RESPONDENT'S POSITION SUMMARY

The carrier did not respond to the Commission's request for additional documentation sent on 9/13/04.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The following disputed date of service was withdrawn by the requestor on 6/9/05 and therefore will not be considered in this review:

CPT code 90885 for date of service 9/8/03.

CPT code 97799 CP on date of service 3/30/04 was denied by the carrier with "N", not appropriately documented. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service, however, the documentation submitted only documents 3 hours of service, not the 8 hours billed. Since the provider did not bill the service with the modifier indicating CARF accreditation, per §134.202 (e)(5)(A)(ii), hourly reimbursement is 80% of MAR. Therefore, **reimbursement is recommended in the amount of $300.00**

CPT code 97799 CP on date of service 4/19/04 was denied by the carrier with "F", reduced according to fee guidelines. The requestor billed 8 hours, and the carrier paid $500 for 5 hours. The information submitted only documents 5 hours of service, therefore, **additional reimbursement is not recommended**.

CPT code 90801- In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 3/8/04 for three (3) hours of psychological testing. This service was rendered on 9/8/03. The carrier denied these sessions for unnecessary medical treatment based on a peer review. Rule 133.301 (a) states "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title." Therefore, reimbursement is **recommended in the amount of $572.64** in accordance with Rule 134.600 (b)(1)(B).

CPT code 97799CP for dates of service 3/29/04, 3/31/04-4/16/04, 4/20/04-4/22/04 (10 sessions): In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 3/24/04 for fifteen (15) hours of a multidisciplinary chronic pain management program (15 sessions). Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFA and certified mail receipt reflected convincing evidence of carrier receipt in accordance with Rule 133.308 (f)(3). Since the provider did not bill the service with the modifier indicating that they are CARF accredited, in accordance with §134.202 (e)(5)(A)(ii), hourly reimbursement is 80% of MAR. Reimbursement is **recommended in the amount of $8800.00**.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $9672.64. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Regina Cleave — Authorized Signature

Regina Cleave — Typed Name

June 24 2005 — Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on 6-27-05. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: 6-28-05